Clara mohammed school stl Authorization for Administration of Prescription Medication

We encourage parents to make every attempt to have medications administered during non-school hours. However, in the event that it is not possible for medications to be administered at home this Authorization for Administration of Prescription Medication must be completed before the school may give the medication to the student. If your child requires medication during the school day the following rules must be observed:

- All medications must be personally brought into the school by the student's parent/guardian accompanied by the appropriate required paperwork.
- All prescription medications require written Authorization for Medication Administration, with original signature by the parent and health care provider before the school shall accept the medication.
- Prescription Medication/Treatment must be received in a pharmacy labeled container with the student's name, healthcare provider's name, name of pharmacy and phone number, name of medication, directions for dosage and date of prescription.
- School personnel shall not administer medication if there is a change in type, dosage or frequency unless a new written Authorization for Medication Administration with original signature by the parent and health care provider is presented to the school official.

Student's Last Name	**Student's First Name**	**Date of Birth**	**Current Grade**

List the condition(s) or disease(s) being treated

How long will your child need this medication	**List your child's allergies**
Who usually prepares and gives medications at home?	**How does your child prefer to take medication?**
Physician's Name	**Physician's Phone Number**
Pharmacy's Name	**Pharmacy's Phone Number**

CLARA MOHAMMED SCHOOL STL AUTHORIZATION FOR ADMINISTRATION OF PRESCRIPTION MEDICATION (PAGE 1 OF 2)

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Who usually prepares and gives medications at home?	**How does your child prefer to take medication?**
Physician's Name	**Physician's Phone Number**
Pharmacy's Name	**Pharmacy's Phone Number**

List each medication your child is required to take at school. (Page 2 of 2)

Medication must be in a properly labeled container prepared by a pharmacist (a prescription), or the manufacturer (non-prescription eye drops). The container must contain the student's name, medication name, dose of the medication, and when to take the medication. Ask your pharmacist for a duplicate prescription container at no extra charge for taking the medication to school.

Name of Medication	**When**	**Dose**	**Route / Administration**	**Self-Administration?**
	Time of day, or what needed for	*One tablet, 2 puffs, 1 teaspoonful, 3 drops, etc.*	*Swallow, inhale in mouth, drops in ear, with food, with a full glass of water, etc.)*	*Does the student administer This medication by self?*
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

List any medications that must be refrigerated:

Has your child ever had a problem with any of these medications?	**Is there anything else you would like us to know about your child & this medicine?**

Consent: As legal parent or guardian, I hereby authorize: (child's name) ____ to take the medication that I will provide, and that is listed in the above profile, and further authorize the school to store these medication according to school policies, and assist with administration of the medication as directed. I further agree to inform the school of any changes in the medication, including changes in when the medication is taken, change in the dose, new or different medication, a reaction to the medication, or discontinuation of medication. I further understand that this consent applies to all medication, whether prescribed by a physician, or purchased over the counter without a prescription. I understand that this consent applies for this school year only, and next year I am required to sign another consent form.

Parent's Signature	**Parent's Printed Name**	**Date Signed**
Physician's Signature	**Physician's Printed Name**	**Date Signed**